Assembly Bill No. 2125

CHAPTER 740

An act to amend Sections 24, 673, 677, 700, 728, 738, 739.5, 739.6, 739.12, 1010, 1063.1, 1063.5, 1064.12, 1077.1, 1215.13, 1656, 1676, 1679, 1707, 1733, 1775.4, 1808, 11521.6,, 11629.85, and 11778 of, and to add Sections 881.2, 1064.13, and 11549 to, the Insurance Code, and to amend Section 12253 of the Revenue and Taxation Code, relating to insurance.

[Approved by Governor September 29, 2006. Filed with Secretary of State September 29, 2006.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2125, Vargas. Insurance.

Existing law regulates the business of insurance, including worker's compensation insurance.

This bill would make numerous changes in the law regulating insurance including workers' compensation insurance.

Among other things, this bill would revise provisions relating to the authority of the Insurance Commissioner to revoke or suspend the State Compensation Insurance Fund's authority to transact workers' compensation insurance. This bill would provide that the fund shall be subject to the powers and authority of the commissioner to the same extent as any other insurer transacting workers' compensation insurance, except where specifically exempted by reference in the provisions of law regulating insurance. This bill would, however, provide that the commissioner may not revoke or suspend the fund's authority to transact workers, compensation insurance. This bill would also exempt the fund from the requirement that a court issue an order vesting title to an insurer's assets in the commissioner under specified circumstances. It would instead require the commissioner to issue a report, as specified, authorize the Governor, in consultation with the Legislature, to replace the fund's president with a recovery administrator, as specified, and require the Governor to direct a course of action to be implemented by the fund's board of directors. This bill would also exempt the fund from delinquency proceedings for insurers and prohibit the commissioner from imposing administrative supervision on it unless it consents. This bill would also allow the fund's board to appoint up to 12 positions, as specified, and fix the salaries of those positions.

As to other types of insurance, the bill would, among other things, revise provisions relating to cancellation and reinstatement of financed insurance, codify current policy of the Department of Insurance regarding agents of nonresident licensees, as specified, modify insurer liquidation

procedure, and change the definition of "commercially domiciled insurer" for purposes of regulating insurance holding companies. The bill would also provide that the Insurance Commissioner may approve a name using the words "savings bank" if the entire title shows that the insurer is engaged in the business of insurance and is not a savings bank. Further, the bill would modify the definition of "insolvent insurer" and modify the California Insurance Guarantee Association refund policy. This bill would also allow the commissioner to create an examination for life agents solely for funeral and burial policies, as specified. This bill would also provide for the merger of foreign and domestic mutual holding companies and require surplus lines brokers who make late monthly payments of premium taxes to pay interest, as specified. This bill would also revise provisions that require the commissioner to prepare and propose a plan regarding low-cost automobile insurance to the relevant Senate and Assembly committees, as specified.

This bill would also make technical, nonsubstantive changes in the law.

The people of the State of California do enact as follows:

SECTION 1. Section 24 of the Insurance Code is amended to read:

24. "Admitted," in relation to a person, means entitled to transact insurance business in this state, having complied with the laws imposing conditions precedent to transaction of such business. The State Compensation Insurance Fund shall be deemed to be admitted pursuant to authority to transact workers' compensation insurance granted by the Legislature. The commissioner shall not revoke or suspend the State Compensation Insurance Fund's authority to transact workers' compensation insurance.

SEC. 2. Section 673 of the Insurance Code is amended to read:

673. (a) As used in this section, "exercise the right to cancel" means the act of formally electing to use the right of the insured to cancel any insurance policy in accordance with and subject to the provisions of that policy when the right to use that right of the insured has been transferred or assigned by the insured in writing executed by, or on behalf of, the insured to a lender who has advanced to the insurer the premium for the policy. The transfer or assignment may be by power of attorney or other document. The transfer or assignment may, but need not, be accompanied by an assignment of any unearned premium due the insured on cancellation.

(b) No lender shall exercise the right to cancel a financed insurance policy because of the default of the insured under a premium payment loan agreement except in accordance with this section.

(c) Written notice of the exercise of the right to cancel shall be mailed by the lender to the insurer and to the insured at the address shown on the premium payment loan agreement or his or her last known address, specifying a date five days or more after the date of mailing of such notice

as the effective date of cancellation. Any insurer may, in writing delivered to the lender, waive, generally or specifically, the right to receive such notice or notices. A copy of such notice may be mailed to the producer of record if known to the lender, but failure to do so shall not affect any rights granted by this section. This subdivision shall not apply to an industrial loan company.

(d) An industrial loan company shall, in giving the insured 10 days' notice of its intent to cancel pursuant to Section 18608 of the Financial Code, furnish a copy of such notice to the insurance agent or insurance broker indicated on the premium finance agreement. After expiration of the 10-day period, the industrial loan company may thereafter, in the name of the insured, cancel the insurance contract or contracts by mailing to the insurer a written notice of cancellation, and the insurance contract shall be canceled as if the notice of cancellation had been submitted by the insured person, but without requiring the return of the insurance contract or contracts. The industrial loan company shall also mail a notice of cancellation, setting forth the effective date of cancellation of the finance insurance contract, to the insured at his or her last known address and to the insurance agent or insurance broker indicated on the premium finance agreement. For the purposes of this subdivision, the words "premium finance agreement" shall have the same meaning as that specified in Section 18564 of the Financial Code.

(e) A written exercise of that right containing a confirmation of the effective date of cancellation shall be mailed by the lender to the insurer within five days following that effective date of cancellation specified in the notice described in subdivision (c) unless the insured has cured any and all defaults. Cancellation shall be effective on the financed insurance policy without requiring the return of the insurance policy or insurance policies, except as provided in subdivisions (f) and (g), on the confirmation date specified in the written exercise of that right. This subdivision shall not apply to an industrial loan company.

(f) All statutory, regulatory, and contractual restrictions providing that the financed insurance policy may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party shall apply where cancellation is effected under this section. The insurer shall give the prescribed notice on behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or before the fifth business day after the day it receives the written exercise of cancellation right containing confirmation of the cancellation date from the lender, as provided in subdivision (e), or a written notice of cancellation from an industrial loan company, pursuant to subdivision (d), and shall, for the purpose of the notice, determine the effective date of cancellation as to those persons mentioned in this subdivision only, taking into consideration the number of days' notice required to complete the cancellation.

(g) Whenever such a financed insurance policy is canceled by any party for any reason:

(1) The insurer shall, in accordance with the written agreements of which it has notice, return to the lender such unearned premiums as are due to the lender. The amount of the return premiums shall be based upon the confirmed date of cancellation specified in subdivision (e), or upon the written notice of cancellation specified in subdivision (d) in the case of an industrial loan company, lessened by the amount, if any, to compensate equitably the insurer for carrying the risk of loss as to any governmental agency, mortgagee, or other parties specified in subdivision (f) from that date to the effective date of cancellation as to those parties.

(2) When a financed insurance policy is canceled, or the insured discontinues payments to a lender, the insurer shall calculate the return premium on a pro rata basis. This paragraph shall not apply to any policy issued under an assigned risk plan or to any policy with respect to which the insurer has made a loan to the insured for the purposes of payment of premiums for the policy.

(h) The commissioner may amend the rules and regulations of any assigned risk plan, fair plan, or similar plan to provide for the equitable assignment of insurance risks among insurers now in existence or hereafter established, in such manner as may be necessary to carry out the purposes of this section.

(i) A lender which sends a written exercise of cancellation right or a written notice of cancellation to an insurer, as provided in subdivision (c), or subdivision (d) in the case of an industrial loan company, thereby represents that he or she has a valid right to do so and to receive the unearned premium. If the lender thereby accomplishes the cancellation and receives an unearned premium, such representation shall be conclusive as between the insurer and the lender. An insurer relying upon the written exercise of that right containing a confirmation of cancellation date and giving, when applicable, notice as required by subdivision (e), shall be relieved from complying with any other duty or form of cancellation required by this code.

(j) This section shall not apply where the insurer exercises its own right to cancel the policy for nonpayment of premium, direct or indirect, or otherwise. Such a cancellation shall be subject to all applicable provisions of the policy, this code, except this section, and any rights of the lender of which the insurer has written notice.

(k) Whenever a lender or industrial loan company cancels a policy as described in this section and then requests the insurer to reinstate the policy, the insurer shall provide written notice by mail to the insured, agent/broker, and lender or industrial loan company within 15 days that the reinstatement has been accepted or rejected.

(*l*) This section shall apply only to contracts entered into between an insured and a lender on or after January 1, 1974.

SEC. 3. Section 677 of the Insurance Code is amended to read:

677. (a) All notices of cancellation shall be in writing, mailed to the named insured at the address shown in the policy, or to his or her last known address, and shall state, with respect to policies in effect after the

time limits specified in Section 676, (1) which of the grounds set forth in Section 676 is relied upon, and, in accordance with the requirements of subdivisions (a) and (e) of Section 791.10, and (2) the specific information supporting the cancellation, the specific items of personal and privileged information that support those reasons, if applicable, and corresponding summary of rights.

(b) For purposes of this section, a lienholder's copy of those notices shall be deemed mailed if, with the lienholder's consent, it is delivered by electronic transmittal, facsimile, or personal delivery.

SEC. 3.1. Section 700 of the Insurance Code is amended to read:

700. (a) A person shall not transact any class of insurance business in this state without first being admitted for that class. Except for the State Compensation Insurance Fund as authorized by Sections 11770 and 11778 to 11780.5, inclusive, admission is secured by procuring a certificate of authority from the commissioner. The certificate shall not be granted until the applicant conforms to the requirements of this code and of the laws of this state prerequisite to its issue.

(b) The unlawful transaction of insurance business in this state in willful violation of the requirement for a certificate of authority is a public offense punishable by imprisonment in the state prison, or in a county jail not exceeding one year, or by fine not exceeding one hundred thousand dollars ($100,000), or by both that fine and imprisonment, and shall be enjoined by a court of competent jurisdiction on petition of the commissioner.

(c) After the issuance of a certificate of authority, the holder shall continue to comply with the requirements as to its business set forth in this code and in the other laws of this state, including, but not limited to, Chapter 5 (commencing with Section 1631), with regard to employees or contractors who solicit, negotiate, or effect insurance.

(d) Where a hearing is held under this section the proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the commissioner shall have all the powers granted therein.

(e) The commissioner shall either issue or deny an application for a certificate of authority within 180 calendar days after the date of the application.

(f) The commissioner and his or her authorized representative shall be prohibited from seeking a waiver to extend the 180 calendar day period specified in subdivision (e), nor shall the applicant be permitted to waive that period.

SEC. 3.2. Section 728 of the Insurance Code is amended to read:

728. (a) For the purposes of this section, the following definitions are applicable:

(1) "Subject person" means any director, officer, or employee or other natural person who participates in the management, direction, or control of an insurer.

(2) "Insurer" means any domestic insurer, and any insurer which is admitted to transact insurance in this state, provided that if a subject person of an insurer is not a resident of California, or operating out of a place of business within California, then the subject person shall be engaged in the direct management, direction, or control of the insurer in California in order to come within the provisions of this section.

(b) If, after notice and a hearing, the commissioner finds all of the following, the commissioner may issue an order removing a subject person from his or her office or employment with the insurer and prohibiting the subject person from further participating in any manner in the conduct of the business of the insurer, except with the prior consent of the commissioner:

(1) The subject person has engaged in repeated acts of misconduct with respect to the operations of an insurer which have resulted in substantial financial loss to an insurer.

(2) The misconduct which forms the pattern is fraudulent, or consists of willful acts or omissions involving personal dishonesty in the acceptance, custody, or payment of money or property on the part of the subject person which has endangered or is likely to endanger the solvency of the insurer.

(3) The pattern of misconduct is relevant in that it demonstrates unfitness to continue as a subject person.

(c) (1) If the commissioner gives written notice pursuant to subdivision (b) to a subject person, the commissioner may immediately issue an order suspending the subject person from his or her office or employment with the insurer and prohibiting the subject person from further participating in any manner in the conduct of the business of an insurer, except with the prior consent of the commissioner if the commissioner: (A) finds that failure to immediately issue such order threatens the financial solvency of the insurer or may otherwise cause immediate and irreparable financial injury to the insurer (B) serves that subject person and the insurer with written notice of the suspension order; and (C) finds that all of the necessary factors are present which would permit the commissioner, after notice and a hearing, to issue an order pursuant to subdivision (b) removing a subject person from his or her office or employment with the insurer and prohibiting the subject person from further participating in any manner in the conduct of the business of an insurer.

(2) Any suspension order issued pursuant to paragraph (1) of this subdivision shall be effective until the date the commissioner dismisses the charges contained in the notice served under subdivision (b) or paragraph (1) of this subdivision, the effective date of an order issued by the commissioner pursuant to subdivision (b), or a court issues a stay of the order pursuant to subdivision (d).

(d) Within 10 days after a subject person has been served with an order of suspension pursuant to subdivision (c), the person may apply to the superior court of the county in which the principal office of the insurer is located for a stay of the order pending completion of the proceedings pursuant to subdivision (b), and the court shall have jurisdiction to issue an

order staying the suspension. Nothing in this subdivision shall be deemed to authorize the court to issue a stay order on an ex parte basis.

(e) (1) If the commissioner finds both of the following, he or she may immediately issue an order suspending a subject person from his or her office or employment with an insurer and prohibiting the subject person from further participating in any manner in the conduct of the business of an insurer, except with the prior consent of the commissioner: (A) the subject person has been charged in an indictment issued by a grand jury, or in an information, complaint, or similar pleading issued by a United States Attorney, district attorney, or other governmental official or agency authorized to prosecute crimes, with a crime punishable by imprisonment for a term exceeding one year and which involves as one of its necessary elements a fraudulent act or an act of dishonesty in the acceptance, custody, or payment of money or property; and (B) that a failure to immediately issue the order threatens the financial solvency of the insurer, or may otherwise cause immediate and irreparable financial injury to the insurer.

In the event the criminal proceedings are terminated other than by judgment of conviction, an order issued pursuant to paragraph (1) of this subdivision shall be deemed rescinded as if it had not been issued.

(2) If the commissioner finds both of the following, he or she may immediately issue an order removing a subject person from his or her office or employment with an insurer and prohibiting the subject person from further participating in any manner in the conduct of the business of the insurer, except with the prior consent of the commissioner: (A) the person has been convicted during the preceding five years of a crime that is punishable by imprisonment for a term exceeding one year and that has as one of its necessary elements a fraudulent act or an act of dishonesty in the accepting, custody, or payment of money or property; and (B) that a failure to immediately issue the order threatens the financial solvency of the insurer, or may otherwise cause immediate and irreparable financial injury to the insurer.

(3) The fact that any subject person charged with a crime involving as one of its necessary elements a fraudulent act or any act of dishonesty in the acceptance, custody, or payment of money or property is not convicted of that crime shall not preclude the commissioner from issuing an order regarding the subject person pursuant to other provisions of this code.

(f) (1) Within 30 days after an order is issued pursuant to subdivision (c) or (e), the person to whom the order is issued may choose to do either of the following: (A) file with the commissioner an application for a hearing on the order. The commissioner shall, upon written request of the person, extend the 30-day period by an additional 30 days provided the request is filed with the commissioner within 30 days after the order is issued. If the commissioner fails to commence the hearing within 15 business days after the application is filed, or within a longer period of time to which the person consents, the order shall be deemed rescinded as if it had not been issued. Within 30 days after the hearing, the

commissioner shall affirm, modify, or rescind the order; otherwise, the order shall be deemed rescinded as if it had not been issued, or (B) petition for judicial review of the order pursuant to Section 1085 of the Code of Civil Procedure, where the court shall exercise its independent judgment on the evidence.

(2) The right of any person to whom an order is issued pursuant to subdivision (c) or (e) to petition for judicial review of the order shall not be affected by the failure of that person to apply to the commissioner for a hearing on the order as provided by this subdivision.

(g) (1) Any person to whom an order is issued pursuant to subdivision (b), (c), or (e) may apply to the commissioner to modify or rescind the order. The commissioner shall not grant the application unless he or she finds that it is reasonable to believe that the person will, if and when he or she becomes a subject person, comply with all of the applicable provisions of this code and of any regulation or order issued thereunder.

(2) The right of any person to whom an order is issued pursuant to subdivision (b), (c), or (e) to petition for judicial review of the order shall not be affected by the failure of that person to apply to the commissioner pursuant to paragraph (1).

(h) (1) It is unlawful for any subject person or former subject person to whom an order is issued pursuant to subdivision (b), (c) or (e) to do any of the following as long as the order is effective, except with the prior consent of the commissioner: (A) to serve or act as a subject person for or in any insurer; or (B) to directly or indirectly solicit, procure, or transfer or attempt to transfer or vote any proxy, consent or authorization with respect to any shares or other securities of any insurer having voting rights.

(2) If, after notice and a hearing, the commissioner finds that any person has violated paragraph (1) of this subdivision, the commissioner may order that person to pay to the commissioner a civil penalty in an amount the commissioner may specify; provided however, that the amount of the civil penalty shall not exceed one thousand dollars ($1,000) for each violation or, in the case of a continuing violation, one thousand dollars ($1,000) for each day for which the violation continues, which may be recovered in a civil action.

In determining the amount of civil penalty to be paid to the commissioner under this paragraph, the commissioner shall consider the financial resources and good faith of the person charged, the gravity of the violation, the history of previous violations by the person, and such other factors as in the opinion of the commissioner may be relevant.

(3) If, after notice and a hearing, the commissioner finds that any insurer has knowingly aided and abetted a subject person in a violation of paragraph (1) of this subdivision, the commissioner may order that insurer to pay to the commissioner a civil penalty in an amount the commissioner may specify; provided however, that the amount of the civil penalty shall not exceed ten thousand dollars ($10,000) for each violation, or in the case of a continuing violation, ten thousand dollars ($10,000) for each day for which the violation continues up to a maximum of one hundred thousand

dollars ($100,000), which may be recovered in a civil action. Continuation of the subject person's salary or other employee benefits pending final disposition shall not be considered aiding and abetting a subject person.

In determining the amount of civil penalty to be paid to the commissioner under this paragraph, the commissioner shall consider the financial resources and good faith of the person charged, the gravity of the violation, the history of previous violations by the person, and such other factors as in the opinion of the commissioner may be relevant.

(i) Except as otherwise provided by this section any hearing required by this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, subject to the following:

(1) At the option of the subject person, all such hearings shall be a closed session and private, and the records of the hearings shall not be made public unless the hearing results in a final order adverse to the subject person.

(2) Where judicial review is sought by the subject person pursuant to Section 11523 of the Government Code, the court shall exercise its independent judgment upon the evidence.

(3) When a subject person to whom an order has been issued pursuant to subdivision (c) or (e) applies to the commissioner for a hearing pursuant to subparagraph (A) of paragraph (1) of subdivision (f), the Office of Administrative Hearings shall schedule the hearing on a priority basis at the earliest possible time and once the hearing is commenced, it shall not be continued for more than three business days without the consent of the subject person.

(4) If the Office of Administrative Hearings cannot schedule the commencement of a hearing within 15 business days as provided by paragraph (1) of subdivision (f), and the subject person does not waive his or her right to a hearing commencing within 15 days, the hearings may be conducted by administrative law judges appointed by the commissioner. In the event the subject person chooses to accept a hearing before an administrative law judge appointed by the commissioner, the hearing shall be completed within 45 days of commencement unless additional time is requested by the subject person. If the hearing is not completed within 45 days, the order shall be deemed rescinded as if it had not been issued.

(j) Nothing in this section is intended to or shall be construed to create a private cause of action against an offending subject person or an insurer or production agency that aids and abets a subject person, based on the standards established by this section or the commissioner's findings or orders pursuant to this section.

(k) Notwithstanding this section, or any other authority of the commissioner, the commissioner shall not have the power to remove or replace either the Board of Directors or the President of the State Compensation Insurance Fund.

SEC. 3.3. Section 738 of the Insurance Code is amended to read:

738. The commissioner shall have the same powers and authority to examine the State Compensation Insurance Fund as are conferred upon him by law relative to the examination of other insurers except where the fund is specifically exempted by reference.

SEC. 3.5. Section 739.5 of the Insurance Code is amended to read:

739.5. (a) "Authorized Control Level Event" means any of the following events:

(1) The filing of an RBC Report by the insurer that indicates that the insurer's Total Adjusted Capital is greater than or equal to its Mandatory Control Level RBC but less than its Authorized Control Level RBC.

(2) The notification by the commissioner to the insurer of an Adjusted RBC Report that indicates the event in paragraph (1), provided the insurer does not challenge the Adjusted RBC Report under Section 739.7.

(3) If the insurer challenges an Adjusted RBC Report that indicates the event in paragraph (1) under Section 739.7, notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) The failure of the insurer to respond, in a manner satisfactory to the commissioner, to a Corrective Order, provided the insurer has not challenged the Corrective Order under Section 739.7.

(5) If the insurer has challenged a Corrective Order under Section 739.7 and the commissioner has, after a hearing, rejected the challenge or modified the Corrective Order, the failure of the insurer to respond, in a manner satisfactory to the commissioner, to the Corrective Order subsequent to rejection or modification by the commissioner.

(b) In the event of an Authorized Control Level Event with respect to an insurer, the commissioner shall do the following:

(1) Take such actions as are required under Section 739.4 regarding an insurer with respect to which a Regulatory Action Level Event has occurred.

(2) If the commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control under Article 14 (commencing with Section 1010), Article 14.3 (commencing with Section 1064.1), Article 14.5 (commencing with Section 1065.1), and Article 15.5 (commencing with Section 1077). In the event the commissioner takes those actions, the Authorized Control Level Event shall be deemed sufficient grounds for the commissioner to take that action, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in those provisions. In the event the commissioner takes actions under this paragraph pursuant to an Adjusted RBC Report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions pertaining to summary proceedings.

(c) In the event of an Authorized Control Level Event with respect to the State Compensation Insurance Fund, the commissioner shall also issue

a report to the Governor, the President pro Tempore of the Senate, and the Speaker of the Assembly setting forth the conditions that exist.

(d) Upon a determination of the commissioner that an Authorized Control Level Event has occurred, the Governor, in consultation with the Legislature, may replace the President of the State Compensation Insurance Fund and appoint a recovery administrator. The recovery administrator shall be responsible for developing a plan of recovery for the State Compensation Insurance Fund, and for implementing the plan. The recovery administrator shall be a person who, through professional credentials or job experience, or both, has a demonstrated understanding of insurance law, insurer finances, experience in the rehabilitation of insurance companies, claims administration, and any other factors as are needed to create and execute a plan of recovery. The cost of the recovery administrator shall be borne by the State Compensation Insurance Fund. The administration shall remain until the commissioner conveys to the Governor his or her opinion that the fund has improved its finances to the extent that it is no longer at the Authorized Control Level or above, at which point the Governor may dismiss the recovery administrator and appoint a new President of the State Compensation Insurance Fund. During the time that the recovery administrator is acting, the board of the State Compensation Insurance Fund shall act in an advisory capacity to the recovery administrator and the Governor.

SEC. 3.6. Section 739.6 of the Insurance Code is amended to read:

739.6. (a) “Mandatory Control Level Event” means any of the following events:

(1) The filing of an RBC Report that indicates that the insurer’s Total Adjusted Capital is less than its Mandatory Control Level RBC.

(2) Notification by the commissioner to the insurer of an Adjusted RBC Report that indicates the event in paragraph (1), provided the insurer does not challenge the Adjusted RBC Report under Section 739.7.

(3) If the insurer challenges an Adjusted RBC Report that indicates the event in paragraph (1) under Section 739.7, notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer’s challenge.

(b) (1) With respect to a life or health insurer, in the event of a Mandatory Control Level Event, the commissioner shall take actions as are necessary to cause the insurer to be placed under regulatory control under Article 14 (commencing with Section 1010), Article 14.3 (commencing with Section 1064.1), Article 14.5 (commencing with Section 1065.1), and Article 15.5 (commencing with Section 1077). In that event, the Mandatory Control Level Event shall be deemed sufficient grounds for the commissioner to take action under those acts, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth therein. In the event the commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to protections as are afforded to insurers under those provisions. Notwithstanding any of the foregoing, the commissioner may forego action for up to 90 days after the

Mandatory Control Level Event if he or she finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the 90-day period.

(2) With respect to a property and casualty insurer, the commissioner shall take those actions as are necessary to place the insurer under regulatory control, or, in the case of an insurer which is writing no business and that is running-off its existing business, may allow the insurer to continue its runoff under the supervision of the commissioner. In either event, the Mandatory Control Level Event shall be deemed sufficient grounds for the commissioner to take action and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Article 14 (commencing with Section 1010). If the commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to the protections of Article 14 (commencing with Section 1010) pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to 90 days after the Mandatory Control Level Event if the commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the 90-day period.

(3) In the event of a Mandatory Control Level Event with respect to the State Compensation Insurance Fund, the commissioner shall also issue a report to the Governor, the President pro Tempore of the Senate, and the Speaker of the Assembly setting forth the conditions that exist.

SEC. 3.7. Section 739.12 of the Insurance Code is amended to read:

739.12. (a) All notices by the commissioner to an insurer that may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the insurer's receipt of such notice.

(b) Copies of all notices from the commissioner to the State Compensation Insurance Fund under this article shall be sent to the Governor.

SEC. 3.8. Section 881.2 is added to the Insurance Code, to read:

881.2. Notwithstanding Section 5652 of the Financial Code, use of the term "savings bank" in a name or title may be approved for use by the commissioner if the remaining words in the name or title show that the insurer is engaged in the business of insurance and is not a savings bank.

SEC. 3.9. Section 1010 of the Insurance Code is amended to read:

1010. (a) The provisions of this article shall apply to all persons, except the State Compensation Insurance Fund, subject to examination by the commissioner, or purporting to do insurance business in this state, or in the process of organization with intent to do such business therein, or from whom the commissioner's certificate of authority is required for the transaction of business, or whose certificate of authority is revoked or suspended.

(b) Notwithstanding subdivision (a), if any of the conditions set forth in Section 1011 exists with respect to the State Compensation Insurance Fund, and the commissioner would otherwise file a verified application

with the superior court or proceed under Section 1013 against the fund, the commissioner shall instead issue a report to the Governor, the President pro Tempore of the Senate, and the Speaker of the Assembly setting forth the conditions that exist and recommending a course to remedy those conditions. The Governor, in consultation with the Legislature, shall direct a course of action to be implemented by the fund's board of directors, or if additional legislative action is necessary, recommend a course of action to the Legislature, or both.

SEC. 4. Section 1063.1 of the Insurance Code is amended to read:

1063.1. As used in this article:

(a) "Member insurer" means an insurer required to be a member of the association in accordance with subdivision (a) of Section 1063, except and to the extent that the insurer is participating in an insolvency program adopted by the United States government.

(b) "Insolvent insurer" means an insurer that was a member insurer of the association, consistent with paragraph (11) of subdivision (c), either at the time the policy was issued or when the insured event occurred, and against which an order of liquidation or receivership with a finding of insolvency has been entered by a court of competent jurisdiction, or, in the case of the State Compensation Insurance Fund, if a finding of insolvency is made by a duly enacted legislative measure.

(c) (1) "Covered claims" means the obligations of an insolvent insurer, including the obligation for unearned premiums, (i) imposed by law and within the coverage of an insurance policy of the insolvent insurer; (ii) which were unpaid by the insolvent insurer; (iii) which are presented as a claim to the liquidator in this state or to the association on or before the last date fixed for the filing of claims in the domiciliary liquidating proceedings; (iv) which were incurred prior to the date coverage under the policy terminated and prior to, on, or within 30 days after the date the liquidator was appointed; (v) for which the assets of the insolvent insurer are insufficient to discharge in full; (vi) in the case of a policy of workers' compensation insurance, to provide workers' compensation benefits under the workers' compensation law of this state; and (vii) in the case of other classes of insurance if the claimant or insured is a resident of this state at the time of the insured occurrence, or the property from which the claim arises is permanently located in this state.

(2) "Covered claims" also include the obligations assumed by an assuming insurer from a ceding insurer where the assuming insurer subsequently becomes an insolvent insurer if, at the time of the insolvency of the assuming insurer, the ceding insurer is no longer admitted to transact business in this state. Both the assuming insurer and the ceding insurer shall have been member insurers at the time the assumption was made. "Covered claims" under this paragraph shall be required to satisfy the requirements of subparagraphs (i) to (vii), inclusive, of paragraph (1), except for the requirement that the claims be against policies of the insolvent insurer. The association shall have a right to recover any deposit, bond, or other assets that may have been required to be posted by the

ceding company to the extent of covered claim payments and shall be subrogated to any rights the policyholders may have against the ceding insurer.

(3) "Covered claims" does not include obligations arising from the following:

(i) Life, annuity, health, or disability insurance.

(ii) Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks.

(iii) Fidelity or surety insurance including fidelity or surety bonds, or any other bonding obligations.

(iv) Credit insurance.

(v) Title insurance.

(vi) Ocean marine insurance or ocean marine coverage under any insurance policy including claims arising from the following: the Jones Act (46 U.S.C.A. Sec. 688), the Longshore and Harbor Workers' Compensation Act (33 U.S.C.A. Sec. 901 et seq.), or any other similar federal statutory enactment, or any endorsement or policy affording protection and indemnity coverage.

(vii) Any claims servicing agreement or insurance policy providing retroactive insurance of a known loss or losses, except a special excess workers' compensation policy issued pursuant to subdivision (c) of Section 3702.8 of the Labor Code that covers all or any part of workers' compensation liabilities of an employer that is issued, or was previously issued, a certificate of consent to self-insure pursuant to subdivision (b) of Section 3700 of the Labor Code.

(4) "Covered claims" does not include any obligations of the insolvent insurer arising out of any reinsurance contracts, nor any obligations incurred after the expiration date of the insurance policy or after the insurance policy has been replaced by the insured or canceled at the insured's request, or after the insurance policy has been canceled by the association as provided in this chapter, or after the insurance policy has been canceled by the liquidator, nor any obligations to any state or to the federal government.

(5) "Covered claims" does not include any obligations to insurers, insurance pools, or underwriting associations, nor their claims for contribution, indemnity, or subrogation, equitable or otherwise, except as otherwise provided in this chapter.

An insurer, insurance pool, or underwriting association may not maintain, in its own name or in the name of its insured, any claim or legal action against the insured of the insolvent insurer for contribution, indemnity or by way of subrogation, except insofar as, and to the extent only, that the claim exceeds the policy limits of the insolvent insurer's policy. In those claims or legal actions, the insured of the insolvent insurer is entitled to a credit or setoff in the amount of the policy limits of the insolvent insurer's policy, or in the amount of the limits remaining, where those limits have been diminished by the payment of other claims.

(6) "Covered claims," except in cases involving a claim for workers' compensation benefits or for unearned premiums, does not include any claim in an amount of one hundred dollars ($100) or less, nor that portion of any claim that is in excess of any applicable limits provided in the insurance policy issued by the insolvent insurer.

(7) "Covered claims" does not include that portion of any claim, other than a claim for workers' compensation benefits, that is in excess of five hundred thousand dollars ($500,000).

(8) "Covered claims" does not include any amount awarded as punitive or exemplary damages, nor any amount awarded by the Workers' Compensation Appeals Board pursuant to Section 5814 or 5814.5 because payment of compensation was unreasonably delayed or refused by the insolvent insurer.

(9) "Covered claims" does not include (i) any claim to the extent it is covered by any other insurance of a class covered by this article available to the claimant or insured nor (ii) any claim by any person other than the original claimant under the insurance policy in his or her own name, his or her assignee as the person entitled thereto under a premium finance agreement as defined in Section 673 and entered into prior to insolvency, his or her executor, administrator, guardian or other personal representative or trustee in bankruptcy and does not include any claim asserted by an assignee or one claiming by right of subrogation, except as otherwise provided in this chapter.

(10) "Covered claims" does not include any obligations arising out of the issuance of an insurance policy written by the separate division of the State Compensation Insurance Fund pursuant to Sections 11802 and 11803.

(11) "Covered claims" does not include any obligations of the insolvent insurer arising from any policy or contract of insurance issued or renewed prior to the insolvent insurer's admission to transact insurance in the State of California.

(12) "Covered claims" does not include surplus deposits of subscribers as defined in Section 1374.1.

(13) "Covered Claims" shall also include obligations arising under an insurance policy written to indemnify a permissibly self-insured employer pursuant to subdivision (b) or (c) of Section 3700 of the Labor Code for its liability to pay workers' compensation benefits in excess of a specific or aggregate retention, provided, however, that for purposes of this article, those claims shall not be considered workers' compensation claims and therefore are subject to the per claim limit in paragraph (7) and any payments and expenses related thereto shall be allocated to category (c) for claims other than workers' compensation, homeowners, and automobile, as provided in Section 1063.5.

These provisions shall apply to obligations arising under any policy as described herein issued to a permissibly self-insured employer or group of self-insured employers pursuant to Section 3700 of the Labor Code and notwithstanding any other provision of the Insurance Code, those

obligations shall be governed by this provision in the event that the Self-Insurers' Security Fund is ordered to assume the liabilities of a permissibly self-insured employer or group of self-insured employers pursuant to Section 3701.5 of the Labor Code. The provisions of this paragraph apply only to insurance policies written to indemnify a permissibly self-insured employer or group of self-insured employers under subdivision (b) or (c) of Section 3700, for its liability to pay workers' compensation benefits in excess of a specific or aggregate retention, and this paragraph does not apply to special excess workers' compensation insurance policies unless issued pursuant to authority granted in subdivision (c) of Section 3702.8 of the Labor Code, and as provided for in clause (vii) of paragraph (3) of subdivision (c). In addition, this paragraph does not apply to any claims servicing agreement or insurance policy providing retroactive insurance of a known loss or losses as are excluded in clause (vii) of paragraph (3) of subdivision (c).

Each permissibility self-insured employer or group of self-insured employers, or the Self-Insurers' Security Fund, shall, to the extent required by the Labor Code, be responsible for paying, adjusting, and defending each claim arising under policies of insurance covered under this section, unless the benefits paid on a claim exceed the specific or aggregate retention, in which case.

(A) If the benefits paid on the claim exceed the specific or aggregate retention, and the policy requires the insurer to defend and adjust the claim, the California Insurance Guarantee Association (CIGA) shall be solely responsible for adjusting and defending the claim, and shall make all payments due under the claim, subject to the limitations and exclusions of this article with regards to covered claims. As to each claim subject to this paragraph, notwithstanding any other provisions of the Insurance Code or the Labor Code, and regardless of whether the amount paid by CIGA is adequate to discharge a claim obligation, neither the self-insured employer, group of employers, nor the Self-Insurers' Security Fund, shall have any obligation to pay benefits over and above the specific or aggregate retention, except as provided in subdivision (c).

(B) If the benefits paid on the claim exceed the specific or aggregate retention, and the policy does not require the insurer to defend and adjust the claim, the permissibility self-insured employer or group of self-insured employers, or the Self-Insurers' Security Fund, shall not have any further payment obligations with respect to the claim, but shall continue defending and adjusting the claim, and shall have the right, but not the obligation, in any proceeding to assert all applicable statutory limitations and exclusions as contained in this article with regard to the covered claim. CIGA shall have the right, but not the obligation, to intervene in any proceeding where the self-insured employer, group of self-insured employers, or the Self-Insurers' Security Fund is defending any such claim and shall be permitted to raise the appropriate statutory limitations and exclusions as contained in this article with respect to covered claims. Regardless of whether the self-insured employer or group of employers, or the

Self-Insurers' Security Fund, asserts the applicable statutory limitations and exclusions, or whether CIGA intervenes in any such proceeding, CIGA shall be solely responsible for paying all benefits due on the claim, subject to the exclusions and limitations of this article with respect to covered claims. As to each claim subject to this paragraph, notwithstanding any other provision of the Insurance Code or the Labor Code and regardless of whether the amount paid by CIGA is adequate to discharge a claim obligation, neither the self-insured employer, group of employers, nor the Self-Insurers' Security Fund, shall have any obligation to pay benefits over and above the specific or aggregate retention, except as provided in this subdivision.

(d) In the event that the benefits paid on the covered claim exceed the per claim limit in paragraph (7) of subdivision (c), the responsibility for paying, adjusting, and defending the claim shall be returned to the permissibly self-insured employer or group of employers, or the Self-Insurers' Security Fund.

These provisions shall apply to all pending and future insolvencies. For purposes of this paragraph, a pending insolvency is one involving a company that is currently receiving benefits from the guaranty association.

(e) "Admitted to transact insurance in this state" means an insurer possessing a valid certificate of authority issued by the department.

(f) "Affiliate" means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

(g) "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10 percent or more of the voting securities of any other person. This presumption may be rebutted by showing that control does not in fact exist.

(h) "Claimant" means any insured making a first party claim or any person instituting a liability claim; provided that no person who is an affiliate of the insolvent insurer may be a claimant.

(i) "Ocean marine insurance" includes marine insurance as defined in Section 103, except for inland marine insurance, as well as any other form of insurance, regardless of the name, label, or marketing designation of the insurance policy, that insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurance such as hull and machinery, marine builders' risks, and marine protection and indemnity. Those perils and risks insured against include, without limitation, loss, damage, or expense or legal liability of the insured arising out of or incident to ownership, operation, chartering,

maintenance, use, repair, or construction of any vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness, or death for loss or damage to the property of the insured or another person.

(j) "Unearned premium" means that portion of a premium that had not been earned because of the cancellation of the insolvent insurer's policy and is that premium remaining for the unexpired term of the insolvent insurer's policy. "Unearned premium" does not include any amount sought as return of a premium under any policy providing retroactive insurance of a known loss or return of a premium under any retrospectively rated policy or a policy subject to a contingent surcharge or any policy in which the final determination of the premium cost is computed after expiration of the policy and is calculated on the basis of actual loss experience during the policy period.

SEC. 4.1. Section 1063.5 of the Insurance Code is amended to read:

1063.5. Each time an insurer becomes insolvent then, to the extent necessary to secure funds for the association for payment of covered claims of that insolvent insurer and also for payment of reasonable costs of adjusting the claims, the association shall collect premium payments from its member insurers sufficient to discharge its obligations. The association shall allocate its claim payments and costs, incurred or estimated to be incurred, to one or more of the following categories: (a) workers' compensation claims; (b) homeowners' claims, and automobile claims, which shall include: automobile material damage, automobile liability (both personal injury and death and property damage), medical payments and uninsured motorist claims; and (c) claims other than workers' compensation, homeowners', and automobile, as above defined. Separate premium payments shall be required for each category. The premium payments for each category shall be used to pay the claims and costs allocated to that category. The rate of premium charged shall be a uniform percentage of net direct written premium in the preceding calendar year applicable to that category. The rate of premium charges to each member in the appropriate categories shall initially be based on the written premium of each insurer as shown in the latest year's annual financial statement on file with the commissioner. The initial premium shall be adjusted by applying the same rate of premium charge as initially used to each insurer's written premium as shown on the annual statement for the second year following the year in which the initial premium charge is made. The difference between the initial premium charge and the adjusted premium charge shall be charged or credited to each member insurer by the association as soon as practical after the filing of the annual statements of the member insurers with the commissioner for the year on which the adjusted premium is based. Any credit due in a specific category to a member insurer as a result of the adjusted premium calculation may be refunded to the member insurer at the discretion of the association if the member insurer has agreed with the commissioner to no longer write insurance in that category but has not withdrawn from the state and

surrendered its certificate of authority. However, in the case of an insurer that was a member insurer when the initial premium charge was made and that paid the initial assessment but is no longer a member insurer at the time of the adjusted premium charge by reason of its insolvency or its withdrawal from the state and surrender of its certificate of authority to transact insurance in this state, any credit accruing to that insurer shall be refunded to it by the association. "Net direct written premiums" shall mean the amount of gross premiums, less return premiums, received in that calendar year upon business done in this state, other than premiums received for reinsurance. In cases of a dispute as to the amount of the net direct written premium between the association and one of its members the written decision of the commissioner shall be final. The premium charged to any member insurer for any of the three categories or a category established by the association shall not be more than 2 percent of the net direct premium written in that category in this state by that member per year, starting on January 1, 2003, until December 31, 2007, and thereafter shall be 1 percent per year. The association may exempt or defer, in whole or in part, the premium charge of any member insurer, if the premium charge would cause the member insurer's financial statement to reflect an amount of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment, no dividends shall be paid to shareholders or policyholders by the company whose premium charge was deferred. Deferred premium charges shall be paid when the payment will not reduce capital or surplus below required minimums. These payments shall be credited against future premium charges to those companies receiving larger premium charges by virtue of the deferment. After all covered claims of the insolvent insurer and expenses of administration have been paid, any unused premiums and any reimbursements or claims dividends from the liquidator remaining in any category shall be retained by the association and applied to reduce future premium charges in the appropriate category. However, an insurer which ceases to be a member of the association, other than an insurer that has become insolvent or has withdrawn from the state and has surrendered its certificate of authority following an initial assessment that is entitled to a refund based upon an adjusted assessment as provided above in this section, shall have no right to a refund of any premium previously remitted to the association. The commissioner may suspend or revoke the certificate of authority to transact business in this state of a member insurer which fails to pay a premium when due and after demand has been made.

Interest at a rate equal to the current federal reserve discount rate plus 2½ percent per annum shall be added to the premium of any member insurer which fails to submit the premium requested by the association within 30 days after the mailing request. However, in no event shall the interest rate exceed the legal maximum.

SEC. 4.2. Section 1064.12 of the Insurance Code is amended to read:

1064.12. (a) This article may be referred to as the "Uniform Insurers Rehabilitation Act."

(b) The Uniform Insurers Rehabilitation Act shall be so interpreted and construed as to effectuate its general purpose to make uniform the law of those states that enact it. To the extent that its provisions, when applicable, conflict with Article 14 (commencing with Section 1010), the provisions of this article shall control. The provisions of Article 14 (commencing with Section 1010) not in conflict with this article shall be unaffected by it.

(c) This article does not apply in regard to insurers domiciled in any state that is not a reciprocal state, and to any insurer domiciled in a reciprocal state before that state appoints a domiciliary receiver for the insurer. All those insurers shall be governed by Article 14 (commencing with Section 1010). If a domiciliary receiver is appointed in a reciprocal state while a receivership is proceeding under Article 14 (commencing with Section 1010), the receiver under that article shall thereafter act as ancillary receiver under Section 1064.3.

(d) This article shall not apply to the State Compensation Insurance Fund.

SEC. 4.4. Section 1064.13 is added to the Insurance Code, to read:

1064.13. (a) Upon receipt of a notice of liquidation the commissioner shall cease imposing, billing or collecting fees and assessments against the subject company pursuant to this code.

(b) Upon receipt of a notice of conservation or administrative supervision the commissioner may cease to impose, bill, or collect fees against the subject company pursuant to this code. Following the date the order has been lifted the commissioner may once again impose, bill, or collect fees against the subject company.

(c) Upon receipt of a notice of liquidation all outstanding invoices, billings or assessments pursuant to this code prior to the date of the notice shall be cancelled.

(d) Upon issuance of a notice of conservation or administrative supervision, outstanding amounts due from the subject company imposed prior to the date of the conservation or administrative supervision, may be held in abeyance and remain unpaid until the conservation or administrative supervision is terminated. Late filing fees accrued pursuant to Section 12995 of this code shall not be imposed.

(e) If it is determined that an insurer is in any of the conditions enumerated in Section 1011, and it is determined that all available funds are needed to pay policyholders, the commissioner may suspend the imposition of fees or assessments until the condition of the insurer has improved to the extent where payment of fees or assessments will not harm policyholders.

SEC. 4.6. Section 1077.1 of the Insurance Code is amended to read:

1077.1. The provisions of the article shall apply to all of the following:

(a) All domestic life or disability insurers, except the State Compensation Insurance Fund.

(b) Any other life or disability insurer doing business in this state whose state of domicile has asked the commissioner to apply the provisions of this article as regards that insurer.

(c) Notwithstanding subdivision (a), the State Compensation Insurance Fund may give its consent to administrative supervision pursuant to paragraph (5) of subdivision (a) of Section 1077.2.

SEC. 5. Section 1215.13 of the Insurance Code is amended to read:

1215.13. (a) For the purposes of this article only, every foreign insurer, except an insurer described in Article 2 (commencing with Section 12350) of Chapter 1 of Part 6 of Division 2, that is authorized to do business in this state and that, during its three preceding fiscal years taken together, or during any lesser period of time if it has been licensed to transact its business in California only for such lesser period of time, has written an average of more direct premiums in the State of California than it has written in its state of domicile during the same period, and those direct premiums written constitute 33 percent or more of its total direct premiums written everywhere in the United States for that three-year or lesser period, as reported in its three most recent annual statements, shall be deemed a "commercially domiciled insurer" within the State of California.

(b) The commissioner may exempt from the provisions of this article any commercially domiciled insurer made subject to this article by subdivision (a) if he or she determines that it has a sufficiently large amount of assets and the evidences of title thereto physically located in California, or that the ratio of those assets to its California policyholder liability is sufficiently large, as to justify the conclusion that there is no reasonable danger that the operations or conduct of the business of the insurer could present a danger of loss to California policyholders. The commissioner may also exempt from the provisions of this article any commercially domiciled insurer made subject to this article by subdivision (a) under the circumstances that he or she deems appropriate.

(c) This section does not exempt any foreign insurer that is authorized to do business in this state, including a commercially domiciled insurer, from the provisions of any other sections of this article that may be applicable to the insurer.

SEC. 5.5. Section 1656 of the Insurance Code is amended to read:

1656. Every applicant for an organizational license shall provide the names of all persons who may exercise the power and perform the duties under the license. Applicants for a nonresident organizational license must name at least one person from their home state who may exercise the power and perform the duties under their license. Additional persons endorsed to that license may be residents of another state, but may not be residents of California.

SEC. 6. Section 1676 of the Insurance Code is amended to read:

1676. (a) Except as set forth in Sections 1675 and 1679, the commissioner shall not issue a permanent license pursuant to this chapter to an applicant therefor unless the applicant has within the 12-month

period next preceding the date of issue of the license taken and passed the qualifying examination for that license. This section shall not apply to a person licensed as a fire and casualty broker-agent who applies for a license as a personal lines broker-agent.

(b) An applicant for a personal lines license pursuant to Section 1625.5 who has been continually employed by an admitted insurer or licensed fire and casualty broker-agent in a full-time position for at least three years immediately prior to January 1, 2001, shall be exempted, at the discretion of the commissioner, from having to take and pass an examination to obtain a personal lines license. An exempted applicant shall be required to comply with all other provisions of this article pertaining to the issuance and maintenance of a personal lines license. The curriculum board shall establish criteria, which shall be submitted to the commissioner for final approval, to allow experience or prior training to be substituted for prelicensing educational requirements for applicants applying for an exemption pursuant to this subdivision. A licensee exempted from examination pursuant to this subdivision shall remain subject to all continuing education requirements applicable to maintaining a personal lines license.

(c) An application for a personal lines license shall be submitted to the commissioner as provided for in Article 4 (commencing with Section 1652).

(d) The commissioner may deny any application for a personal lines license as provided in Article 6 (commencing with Section 1666).

(e) In addition to the application, any applicant for a personal lines license seeking exemption from the examination provisions of this chapter shall also submit, on a form prescribed by the commissioner, or if a form is not prescribed, in letter or resumé form, information that will permit the commissioner to determine whether the previous experience of the applicant for a personal lines license warrants an exemption from having to take an examination to obtain a license.

(f) The commissioner shall require an applicant for a personal lines license to take an examination to obtain a license if the commissioner determines that the applicant has failed to demonstrate that previous experience warrants an exemption from examination. In the absence of making that determination, the request for exemption from examination shall be granted.

(g) This section shall not be applicable to any applicant for a nonresident license pursuant to subdivision (b) of Section 1639.

(h) This section shall not be applicable to any applicant for a personal lines license who has been refused a license or has had a license suspended or revoked by the commissioner.

(i) An applicant for a personal lines license pursuant to Section 1625.5 who seeks an exemption from an examination to obtain a license shall submit a request to that effect to the commissioner. An applicant who does not submit an application on or before December 31, 2001, shall be required to take an examination to obtain a license.

(j) An applicant for a life agent license pursuant to Section 1626 who is limited by the terms of a written agreement with an insurer which has filed on that life agent's behalf a notice of appointment with the commissioner to transact only specific life insurance policies or annuities having an initial face amount of fifteen thousand dollars ($15,000) or less that are designated by the purchaser for the payment of funeral and burial expenses, shall not be required to take the full life agent examination to obtain a license. The applicant shall be required to take an examination developed to test their knowledge of topics relevant to the type of policies that they are restricted to sell.

SEC. 6.5. Section 1679 of the Insurance Code is amended to read:

1679. (a) A nonresident applicant for a license shall be subject to the same qualifying examination as is required of a resident applicant. The examination may be administered to an eligible nonresident applicant through the insurance authority of the state, territory of the United States, or province of Canada of his or her residence; provided, however, that the commissioner may, in his or her discretion, enter into a reciprocal arrangement with the officer having supervision of the insurance business in any other state, territory of the United States, or province of Canada whose qualification standards for the applicant to be examined are substantially the same as or in excess of those of this state, to accept, in lieu of the examination of an applicant residing therein, a certificate of the officer to the effect that the applicant is licensed in that state, territory of the United States, or province of Canada in a capacity similar to that for which a license is sought in this state and has complied with its qualification standards in respect to the following:

(1) Experience or training,

(2) Reasonable familiarity with the broad principles of insurance licensing and regulatory laws and with the provisions, terms and conditions of the insurance which the applicant proposes to transact, and

(3) A fair and general understanding of the obligations and duties of a holder of the license sought.

(b) The provisions of this section shall not apply to a nonresident applicant who maintains a license in a jurisdiction that grants reciprocity to California residents in accordance with Section 1638.5.

(c) A nonresident applicant for an organizational license must name at least one person from their home state who may exercise the power and perform the duties under their license. Additional persons endorsed to that license may be residents of another state, but may not be residents of California.

SEC. 7. Section 1707 of the Insurance Code is amended to read:

1707. Except as otherwise provided in Section 1704.5, each notice of appointment or notice of termination of appointment filed pursuant to this article shall be filed on forms prescribed by the commissioner within 15 days of appointment or termination.

SEC. 8. Section 1733 of the Insurance Code is amended to read:

1733. All funds received by any person acting as an insurance agent, broker, or solicitor, life agent, life analyst, surplus line broker, special lines surplus line broker, motor club agent, bail agent, permittee, administrator as defined in Section 1759, or solicitor, as premium or return premium on or under any policy of insurance or undertaking of bail, are received and held by that person in his or her fiduciary capacity. Any such person who diverts or appropriates those fiduciary funds to his or her own use is guilty of theft and punishable for theft as provided by law. Any premium that a premium financer agrees to advance pursuant to the terms of a premium finance agreement shall constitute fiduciary funds as defined in this section only if actually received by a person licensed in one or more of the capacities herein specified.

SEC. 9. Section 1775.4 of the Insurance Code is amended to read:

1775.4. (a) The amount of the payment shall be 3 percent of the gross premiums less return premiums upon business done by the surplus line broker under the authority of his or her license during the calendar month ending two calendar months immediately preceding the due date of the payment, as specified in Section 1775.3, excluding gross premiums and return premiums paid by him or her upon business governed by the provisions of Section 1760.5. If during any calendar month those return premiums upon business done by a surplus line broker exceed the gross premiums upon the business done by him or her in that calendar month, then no payment shall be payable by him or her in respect to that calendar month, and he or she may carry forward that excess to the next succeeding calendar month or months and apply it in reduction of the taxable premiums on business done by him or her in that succeeding calendar month or months. Even though no payment shall be payable by the broker, he or she shall file a return showing that his or her return premiums exceeded his or her gross premiums.

(b) In determining the applicability of subdivision (a) of Section 1775.1 to a surplus line broker who has acquired the business of another surplus line broker, the amount of tax liability of the acquired broker for the immediately preceding calendar year shall be added to the amount of the tax liability of the acquiring broker for the immediately preceding calendar year.

(c) All amounts paid, other than penalties and interest, shall be allowed as a credit on the annual tax imposed by Section 1775.5.

(d) If the total amount of monthly installment payments for any calendar year exceeds the amount of annual tax for that year, the excess shall be treated as an overpayment of annual tax and be allowed as a credit or refund.

(e) A penalty of 10 percent of the amount of the monthly payment due shall be levied upon and paid by any surplus line broker who fails to make the necessary payment within the time required, plus interest at the rate of 1 percent per calendar month or fraction thereof from the due date of the payment until the date payment is received by the commissioner, but not for any period after the due date of the annual tax. The penalty and interest

shall be applied as prescribed in Section 12636.5 of the Revenue and Taxation Code. The commissioner may remit the penalty in a case where he or she finds, as a result of examination or otherwise, that the failure of, or delay in, payment arose out of excusable mistake or excusable inadvertence.

(f) For any part of a payment required that was not made within the time required by law, when the nonpayment or late payment was due to fraud on the part of the taxpayer, a penalty of 25 percent of the amount unpaid shall be added thereto, in addition to all other penalties otherwise imposed.

(g) The commissioner, upon a showing of good cause, may extend for not to exceed 10 days the time for making a monthly payment. The extension may be granted at any time, provided that a request therefor is filed with the commissioner within or prior to the period for which the extension may be granted. Any surplus line broker to whom an extension is granted shall, in addition to the monthly payment, pay interest at the rate of 1 percent per month, or fraction thereof, from the due date until the annual tax due date.

SEC. 10. Section 1808 of the Insurance Code is amended to read:

1808. (a) Annual notices of intention to keep licenses in force or applications for renewal of licenses, as the case may be, may be filed on or before June 30th of each year upon payment of the fees for filing specified in Section 1811.

(b) Upon failure to file such notice or application as provided in subdivision (a), the license shall expire on July 1st, but the holder may file an application for a new license. Until June 30th next succeeding the fee shall be twice that specified in Section 1811 for such filing.

(c) No notice or application shall be deemed filed within the meaning of this section unless the document itself has been actually delivered to, and the proper fee for its filing has been paid at, the office of the commissioner during office hours, or unless both such document and fee have been filed and remitted pursuant to Sections 11002 and 11003 of the Government Code.

SEC. 11. Section 11521.6 of the Insurance Code is amended to read:

11521.6. Nothing contained in Section 11521, 11521.1, 11521.2, 11521.4, 11523.6, or paragraph (6) of subdivision (a) of Section 11523 shall apply to any grants and annuities certificate holder that also holds a certificate of authority pursuant to Article 3 (commencing with Section 699) of Chapter 1 of Part 2 of Division 1. A grants and annuities certificate holder subject to this section shall display clearly and conspicuously, and in the type specified, the disclosure required by paragraph (7) of subdivision (a) of Section 11523 in all agreements issued under this chapter.

SEC. 12. Section 11549 is added to the Insurance Code, to read:

11549. (a) Pursuant to this section, a mutual holding company may merge into a foreign mutual holding company that is domiciled in a state to which the converted insurer has transferred its domicile or will transfer

its domicile concurrently with the merger. The merger shall be effected pursuant to an agreement of merger between the mutual holding company and the foreign mutual holding company in accordance with the General Corporation Law, to the extent not inconsistent with this section. The merger shall take effect upon filing the agreement of merger with the California Secretary of State after compliance with the following:

(1) Approval of the agreement of merger by a resolution of the majority of the board of directors of the mutual holding company and signing of the agreement of merger by the parties thereto.

(2) Approval of an amendment to the converted insurer's plan of conversion in accordance with Section 11547 by a resolution of the majority of the board of directors of the converted insurer in order to reflect appropriately the merger and transfer of domicile.

(3) Submission of the agreement of merger and the amendment to the commissioner for consent in writing.

(4) Approval of the agreement of merger by a majority of the members of the mutual holding company who vote at a meeting called for that purpose.

(5) Approval of the amendment by a majority of the members of the mutual holding company who were members of the converted insurer and were entitled to vote on the original plan of conversion approved pursuant to subdivision (c) of Section 11536 and who vote at a meeting called for the purpose.

(6) Filing of the agreement of merger in the office of the commissioner after having been consented to and approved as contemplated by paragraphs (2), (3), (4), and (5).

(b) The submission to the commissioner prescribed in paragraph (3) of subdivision (a) shall be accompanied by a filing fee of eight thousand one hundred dollars ($8,100), evidence that the foreign mutual holding company that will survive the merger is qualified as a foreign corporation under the General Corporation Law, and any other relevant information that the commissioner may require.

(c) The meetings of members prescribed in paragraphs (4) and (5) of subdivision (a) and shall be called by the board of directors, the chairperson of the board, or the president of the mutual holding company, and may be combined at a single meeting with separate voting by those eligible to vote on the matters referred to in paragraphs (4) and (5) of subdivision (a). Notice of the meeting shall be given by mail to members entitled to vote at the meeting at least 30 days prior to the date set for the meeting. Voting shall be by ballot, in person, or by proxy. A quorum for each such matter consists of 5 percent of the members of the mutual holding company entitled to vote at the meeting on the matter.

(d) The commissioner shall consent to any proposed merger and amendment if he or she determines that the merger will be fair and equitable to the mutual holding company and its members.

SEC. 13. Section 11629.85 of the Insurance Code is amended to read:

11629.85. (a) On or before March 1 of each year, the commissioner shall prepare and propose a plan to the Senate Committee on Banking, Finance, and Insurance and the Assembly Committee on Insurance setting forth the methods the commissioner intends to implement to inform households eligible for the program about the availability of low-cost automobile insurance. To be eligible for funding through the budget process, the plan shall be reviewed by the Senate Committee on Banking, Finance, and Insurance and the Assembly Committee on Insurance. The information required under subdivision (c) shall also be provided to the Senate Committee on Transportation and Housing and the Assembly Committee on Transportation.

(b) The plan shall include, at a minimum, a brief description of methods proposed to be used, anticipated costs, sources of revenue, goals, targets, objectives, and a justification of the proposed methods. The plan shall also explain how the department proposes to work in cooperation with the California Automobile Assigned Risk Plan, the social service departments in eligible counties, the Department of Motor Vehicles, and community-based organizations in order to inform eligible households of the existence of the program.

(c) The plan shall also include all of the following:

(1) The commissioner's determination regarding whether the program has been successful, based on the criteria specified in subdivision (d), and an explanation regarding that success or lack thereof.

(2) In cooperation with the California Automobile Assigned Risk Plan, structural characteristics of the program that may require statutory revision in order for the program to succeed or to improve upon existing success.

(3) Impediments to success of the program that can reasonably be overcome by revision to the strategies adopted by the department.

(4) A detailed explanation of the department's use for the program of funds assessed pursuant to Section 1872.81.

(5) For the previous calendar year, a list of the total low-cost auto premium for each county in which the program was available.

(6) The most recent annual report to the Legislature on the status of the low-cost automobile insurance program from the California Automobile Assigned Risk Plan.

(d) The program is successful if the following occur:

(1) The program generated sufficient premiums to cover losses incurred under policies issued under the program, and expenses incurred by the program, as calculated pursuant to subdivision (c) of Section 11629.72.

(2) The program served the public purpose of offering access to automobile insurance to otherwise underserved communities in the program areas.

(3) The program offered access to automobile insurance to previously uninsured motorists seeking affordable coverage in the program areas.

(e) Any written or oral advertisements, including, but not limited to, paid or unpaid commercial or noncommercial advertising, by the department with reference to the low-cost automobile insurance program

shall reference the department and shall not reference the commissioner by name or office, or include the commissioner's voice, image, or likeness. The department shall not participate with any nongovernmental entity that produces or intends to produce advertisements or educational material that include the name of the commissioner or his or her voice, image or likeness, and that are intended to make eligible households aware of the existence of low-cost automobile insurance.

SEC. 13.1. Section 11778 of the Insurance Code is amended to read:

11778. The fund may transact workers' compensation insurance required or authorized by law of this state to the same extent as any other insurer. The fund shall be subject to the powers and authority of the commissioner to the same extent as any other insurer transacting workers' compensation insurance, except where specifically exempted by reference. For purposes of Section 700, the fund shall be deemed admitted to transact this class of insurance.

SEC. 14. Section 12253 of the Revenue and Taxation Code is amended to read:

12253. Each insurer required to make prepayments shall remit them on or before each of the dates of April 1st, June 1st, September 1st and December 1st of the current calendar year. Remittances for prepayments shall be made payable to the Controller and shall be delivered to the office of the commissioner, accompanied by a prepayment form prescribed by the commissioner.

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